

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-045400

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11923

STATE FILE NUMBER

FILED DEC 12 1963

I. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis, Missouri

Length of stay in 1b
2-days

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Missouri b. COUNTY

c. CITY OR TOWN St. Louis Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR INSTITUTION BARNES HOSPITAL

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
4674 Tesson St. Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

First Middle Last
Johanna Eckrich

4. DATE OF DEATH
December 1, 1963

5. SEX

Female

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH

5/29/98

9. AGE (last birthday)

65

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HR

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housekeeping

10b. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (City and state or country)

St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Andrew Hoefel

13b. MOTHER'S MAIDEN NAME

Anne Doetzel

14. NAME OF HUSBAND OR WIFE

John Eckrich

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)
no

16. SOCIAL SECURITY NO.

17. INFORMANT

John Eckrich - 4674 Tesson St.

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH
Years

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 11/29/63 to 12/1/63 and last saw her alive on 12/1/63
Death occurred at 5:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Deceased or title)

M. J. M.D.

22b. ADDRESS

BARNES HOSPITAL

22c. DATE SIGNED

12/2/63

23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal

23b. DATE

Dec. 4, 1963

23c. NAME OF CEMETERY OR CREMATORY

Resurrection Cemetery

23d. LOCATION (City, town, or county)

St. Louis County, Missouri

24. FUNERAL DIRECTOR

ADDRESS

WACKER-HELDERLE-3634 Gravois Ave.

25. DATE RECD. BY LOCAL REG.

DEC 3 1963

26. REGISTRAR'S SIGNATURE

Boal Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4375

P. O. Address St. Louis 14 Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.